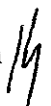




**M E M O R A N D U M**

**Date:** November 19, 2008

**To:** Nancy Costello, CFO, Streamwood Hospital

**From:** Kevin Smith 

**RE: MEDICARE / MEDICAID COST REPORTS  
FYE 6/30/08**

---

Thank you for all the work you and your staff did to facilitate the filing of this cost report. Enclosed are the following items relating to your cost report:

1. Package for Wisconsin Physician Service (Medicare)
2. Package for Illinois HFS (Medicaid)
3. Hospital Copies
4. Copies of signature pages to return to me.

Please ask Cindy to sign all signature pages of the cost reports. I have attached "Sign Here" stickers at all places requiring signatures. Please send me a copy of the signed pages.

If you have any questions, please let me know.

cc: Dan Mullins, Vice President of Reimbursement, PSI  
Jack Barzilai, CFO, Midwest Division, PSI  
Cindy Meyer, CEO, Streamwood Hospital

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).  
 FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE  
 THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS  
 (42 USC 1395g).

WORKSHEET S  
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-4034	I	FROM 7/ 1/2007	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 6/30/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
					I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/19/2008 TIME 14:29

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:  
 STREAMWOOD 14-4034  
 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

*Cindy Meizer*  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
 TITLE  
 11/20/08  
 DATE

ECR ENCRYPTION INFORMATION  
 DATE: 11/19/2008 TIME 14:29

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PI ENCRYPTION INFORMATION  
 DATE: 11/19/2008 TIME 14:29

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 T4jp3w2HGL0:frZz

PART II - SETTLEMENT SUMMARY

TITLE V		TITLE XVIII		TITLE XIX	
1	2	3	4	5	6
100	HOSPITAL TOTAL	0	0	0	-9,199,778
		0	0	0	-9,199,778

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).  
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE  
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS  
(42 USC 1395g).

FORM APPROVED  
OMB NO. 0938-0050

WORKSHEET 5  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH	I	PROVIDER NO:	I PERIOD	I INTERMEDIARY USE ONLY	I	DATE RECEIVED:
CARE COMPLEX	I	14-4034	I FROM 7/ 1/2007	I --AUDITED --DESK REVIEW	I	/ /
COST REPORT CERTIFICATION	I		I TO 6/30/2008	I --INITIAL --REOPENED	I	INTERMEDIARY NO:
AND SETTLEMENT SUMMARY	I		I	I --FINAL 1-MCR CODE	I	
				I 00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/19/2008 TIME 14:29

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:  
STREAMWOOD 14-4034

FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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ECR ENCRYPTION INFORMATION  
DATE: 11/19/2008 TIME 14:29  
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PI ENCRYPTION INFORMATION  
DATE: 11/19/2008 TIME 14:29  
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\_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

PART II - SETTLEMENT SUMMARY

	TITLE V		A 2	TITLE XVIII	B 3	TITLE XIX	
1							
100	HOSPITAL	0		0		0	-9,199,778
	TOTAL	0		0		0	-9,199,778

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
IDENTIFICATION DATA

I PROVIDER NO:	I PERIOD:	I PREPARED 11/19/2008
I 14-4034	I FROM 7/ 1/2007	I WORKSHEET S-2
I	I TO 6/30/2008	I

## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 1400 EAST IRVING PARK	P.O. BOX:	
1.01 CITY: STREAMWOOD	STATE: IL	ZIP CODE: 60107- COUNTY: COOK

## HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)
0	1	2	2.01	3	V XVIII XIX 4 5 6
02.00 HOSPITAL	STREAMWOOD	14-4034		5/ 1/1991	N T T

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2007 TO: 6/30/2008

18 TYPE OF CONTROL

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL  
20 SUBPROVIDER

## OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).  
21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N N

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION IN COL. 3. / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COLUMN 3. / /

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&amp;R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N

25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
IDENTIFICATION DATAI PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
I 14-4034 I FROM 7/ 1/2007 I WORKSHEET S-2  
I TO 6/30/2008 I

- 25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
- 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.
- 26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
- 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
- 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. N / /
- 28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02
- 28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)
- 28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY

	1	2	3	4
	0	0.0000	0.0000	
	0.00	0		

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

- |   | %     | Y/N |
|---|-------|-----|
| 28.03 STAFFING  | 0.00% |     |
| 28.04 RECRUITMENT   | 0.00% |     |
| 28.05 RETENTION   | 0.00% |     |
| 28.06 TRAINING  | 0.00% |     |
| 28.07   | 0.00% |     |
| 28.08   | 0.00% |     |
| 28.09   | 0.00% |     |
| 28.10   | 0.00% |     |
| 28.11   | 0.00% |     |
| 28.12   | 0.00% |     |
| 28.13   | 0.00% |     |
| 28.14   | 0.00% |     |
| 28.15   | 0.00% |     |
| 28.16   | 0.00% |     |
| 28.17   | 0.00% |     |
| 28.18   | 0.00% |     |
| 28.19   | 0.00% |     |
| 28.20   | 0.00% |     |
| 29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?   |       | N   |
| 30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)   |       | N   |
| 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70  |       |     |
| 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)   |       |     |
| 30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).   |       |     |
| 30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II |       |     |
| 31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).  |       | N   |
| 31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).  |       | N   |
| 31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).  |       | N   |
| 31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).  |       | N   |
| 31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).  |       | N   |
| 31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).  |       | N   |

## MISCELLANEOUS COST REPORT INFORMATION

- 32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N
- 33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 N
- 34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N
- 35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
- 35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
- 35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
- 35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
- 35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

V XVIII XIX

## PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

- 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)
- 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE

	1	2	3
	N	N	N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
IDENTIFICATION DATAI PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
I 14-4034 I FROM 7/ 1/2007 I WORKSHEET S-2  
I I TO 6/30/2008 I

WITH 42 CFR 412.320? (SEE INSTRUCTIONS)

37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N  
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

## TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? Y  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N  
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N  
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N  
 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?  
 IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.  
 IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y 4-9000  
 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #  
 40.02 STREET: P.O. BOX:  
 40.03 CITY: STATE: ZIP CODE: -  
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.  
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  
 46 IF YOU ARE PARTICIPATING IN THE NCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)  
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N  
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N  
 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0  
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:  
 PREMIUMS: 0  
 PAID LOSSES: 0  
 AND/OR SELF INSURANCE: 0  
 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N  
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEE 4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00	N	0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N  
 58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N N  
 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) Y N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
IDENTIFICATION DATA

IN LIEU OF FORM CMS-2552-96 (05/2008) CONTD  
I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
I 14-4034 I FROM 7/ 1/2007 I WORKSHEET S-2  
I I TO 6/30/2008 I

60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).

N N 0

MULTICAMPUS

61.00 DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00
62.01					0.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET S-3
I		I	TO 6/30/2008	I	PART I

COMPONENT		NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH N/A 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	117	42,822					29,481
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	117	42,822					29,481
6	INTENSIVE CARE UNIT							
7	CORONARY CARE UNIT							
8	BURN INTENSIVE CARE UNIT							
9	SURGICAL INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL	117	42,822					29,481
13	RPCH VISITS							
14	SUBPROVIDER	14	5,124					
16	NURSING FACILITY							
25	TOTAL	131						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

COMPONENT		TITLE XIX OBSERVATION ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	DISCHARGES NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			37,888				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			37,888				
6	INTENSIVE CARE UNIT							
7	CORONARY CARE UNIT							
8	BURN INTENSIVE CARE UNIT							
9	SURGICAL INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL			37,888				
13	RPCH VISITS							
14	SUBPROVIDER			5,004				
16	NURSING FACILITY							
25	TOTAL							
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

COMPONENT		I & R FTES NET 9	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS						1,597	1,866
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
7	CORONARY CARE UNIT							
8	BURN INTENSIVE CARE UNIT							
9	SURGICAL INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL		243.72				1,597	1,866
13	RPCH VISITS							
14	SUBPROVIDER		17.68					12
16	NURSING FACILITY							
25	TOTAL		261.40					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							



## HOSPITAL WAGE INDEX INFORMATION

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET S-3  
 I I TO 6/30/2008 I PARTS II & III

PART II - WAGE DATA		AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
1	SALARIES						
2	TOTAL SALARY	14,866,011		14,866,011			
3	NON-PHYSICIAN ANESTHETIST PART A						
4	NON-PHYSICIAN ANESTHETIST PART B						
4.01	PHYSICIAN - PART A TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5	PHYSICIAN - PART B						
5.01	NON-PHYSICIAN - PART B						
6	INTERNS & RESIDENTS (APPRVD)						
6.01	CONTRACT SERVICES, I&R						
7	HOME OFFICE PERSONNEL						
8	SNF						
8.01	EXCLUDED AREA SALARIES	1,302,712	74,705	1,377,417			
9	OTHER WAGES & RELATED COSTS						
9.01	CONTRACT LABOR: PHARMACY SERVICES UNDER CONTRACT						
9.02	LABORATORY SERVICES UNDER CONTRACT						
9.03	MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10	CONTRACT LABOR: PHYS PART A						
10.01	TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11	HOME OFFICE SALARIES & WAGE RELATED COSTS						
12	HOME OFFICE: PHYS PART A						
12.01	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
13	WAGE RELATED COSTS						
14	WAGE-RELATED COSTS (CORE)						CMS 339
15	WAGE-RELATED COSTS (OTHER)						CMS 339
16	EXCLUDED AREAS						CMS 339
17	NON-PHYS ANESTHETIST PART A						CMS 339
18	NON-PHYS ANESTHETIST PART B						CMS 339
18.01	PHYSICIAN PART A						CMS 339
19	PART A TEACHING PHYSICIANS						CMS 339
19.01	PHYSICIAN PART B						CMS 339
20	WAGE-RELATD COSTS (RHC/FQHC)						CMS 339
21	INTERNS & RESIDENTS (APPRVD)						CMS 339
22	OVERHEAD COSTS - DIRECT SALARIES						
22.01	EMPLOYEE BENEFITS	310,452		310,452			
23	ADMINISTRATIVE & GENERAL	2,506,510	-184,269	2,322,241			
24	A & G UNDER CONTRACT						
25	MAINTENANCE & REPAIRS	155,571		155,571			
26	OPERATION OF PLANT						
26.01	LAUNDRY & LINEN SERVICE						
27	HOUSEKEEPING	8,136		8,136			
27.01	HOUSEKEEPING UNDER CONTRACT						
28	DIETARY	243,479		243,479			
29	CAFETERIA						
30	MAINTENANCE OF PERSONNEL						
31	NURSING ADMINISTRATION	963,073		963,073			
32	CENTRAL SERVICE AND SUPPLY						
33	PHARMACY						
34	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	184,899		184,899			
35	SOCIAL SERVICE	994,686		994,686			
	OTHER GENERAL SERVICE						
PART III - HOSPITAL WAGE INDEX SUMMARY							
1	NET SALARIES	14,866,011		14,866,011			
2	EXCLUDED AREA SALARIES	1,302,712	74,705	1,377,417			
3	SUBTOTAL SALARIES	13,563,299	-74,705	13,488,594			
4	SUBTOTAL OTHER WAGES & RELATED COSTS						
5	SUBTOTAL WAGE-RELATED COSTS						
6	TOTAL	13,563,299	-74,705	13,488,594			
7	NET SALARIES						
8	EXCLUDED AREA SALARIES						
9	SUBTOTAL SALARIES						
10	SUBTOTAL OTHER WAGES & RELATED COSTS						
11	SUBTOTAL WAGE-RELATED COSTS						
12	TOTAL						
13	TOTAL OVERHEAD COSTS	5,366,806	-184,269	5,182,537			

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:

I 14-4034

I

I PERIOD:

I FROM 7/ 1/2007

I TO

6/30/2008

I PREPARED 11/19/2008

I WORKSHEET A

I

	COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		681,598	681,598	175,410	857,008
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		168,325	168,325	90,550	258,875
5	0500	EMPLOYEE BENEFITS	310,452	1,343,736	1,654,188	-6,850	1,647,338
6	0600	ADMINISTRATIVE & GENERAL	2,506,510	2,628,834	5,135,344	-464,491	4,670,853
7	0700	MAINTENANCE & REPAIRS	155,571	554,172	709,743	-1,808	707,935
8	0800	OPERATION OF PLANT					
9	0900	LAUNDRY & LINEN SERVICE		229,057	229,057		229,057
10	1000	HOUSEKEEPING	8,136	232,140	240,276		240,276
11	1100	DIETARY	243,479	438,597	682,076		682,076
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	963,073	118,664	1,081,737	-2,261	1,079,476
17	1700	MEDICAL RECORDS & LIBRARY	184,899	341,459	526,358	-6,970	519,388
18	1800	SOCIAL SERVICE	994,686	102,922	1,097,608	-4,299	1,093,309
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	7,235,818	922,489	8,158,307	34,537	8,192,844
26	2600	INTENSIVE CARE UNIT					
27	2700	CORONARY CARE UNIT					
28	2800	BURN INTENSIVE CARE UNIT					
29	2900	SURGICAL INTENSIVE CARE UNIT					
31	3100	SUBPROVIDER	697,826	92,811	790,637	193,142	983,779
33	3300	NURSERY					
35	3500	NURSING FACILITY					
		ANCILLARY SRVC COST CNTRS					
41	4100	RADIOLOGY-DIAGNOSTIC					
44	4400	LABORATORY		67,086	67,086	2,854	69,940
53	5300	ELECTROCARDIOLOGY	124,162	305,447	429,609		429,609
56	5600	DRUGS CHARGED TO PATIENTS		830,832	830,832		830,832
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	836,513	85,814	922,327	-1,654	920,673
		SPEC PURPOSE COST CENTERS					
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	14,261,125	9,143,983	23,405,108	8,160	23,413,268
		NONREIMBURS COST CENTERS					
98	9800	PHYSICIANS' PRIVATE OFFICES					
100	7950	NORTHWEST ACADAMY					
100.01	7951	INPATIENT SCHOOL	283,597	34,422	318,019	-3,166	314,853
100.02	7952	COMMUNITY RELATIONS	321,289	121,022	442,311	-4,994	437,317
100.03	7953	CLINICAL TRIALS					
101		TOTAL	14,866,011	9,299,427	24,165,438	-0-	24,165,438

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:	I PERIOD:	I PREPARED 11/19/2008
I 14-4034	I FROM 7/ 1/2007	I WORKSHEET A
I	I TO 6/30/2008	I

COST CENTER		COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	46,933	903,941
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	32,461	291,336
5	0500	EMPLOYEE BENEFITS	-407,380	1,239,958
6	0600	ADMINISTRATIVE & GENERAL	-401,250	4,269,603
7	0700	MAINTENANCE & REPAIRS	-3,047	704,888
8	0800	OPERATION OF PLANT		
9	0900	LAUNDRY & LINEN SERVICE		229,057
10	1000	HOUSEKEEPING		240,276
11	1100	DIETARY	-13,768	668,308
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		1,079,476
17	1700	MEDICAL RECORDS & LIBRARY	-12,972	506,416
18	1800	SOCIAL SERVICE		1,093,309
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-1,692,620	6,500,224
26	2600	INTENSIVE CARE UNIT		
27	2700	CORONARY CARE UNIT		
28	2800	BURN INTENSIVE CARE UNIT		
29	2900	SURGICAL INTENSIVE CARE UNIT		
31	3100	SUBPROVIDER	-75,104	908,675
33	3300	NURSERY		
35	3500	NURSING FACILITY		
		ANCILLARY SRVC COST CNTRS		
41	4100	RADIOLOGY-DIAGNOSTIC		
44	4400	LABORATORY		69,940
53	5300	ELECTROCARDIOLOGY	-174,188	255,421
56	5600	DRUGS CHARGED TO PATIENTS		830,832
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC	-210,634	710,039
		SPEC PURPOSE COST CENTERS		
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-2,911,569	20,501,699
		NONREIMBURS COST CENTERS		
98	9800	PHYSICIANS' PRIVATE OFFICES		
100	7950	NORTHWEST ACADAMY		
100.01	7951	INPATIENT SCHOOL		314,853
100.02	7952	COMMUNITY RELATIONS		437,317
100.03	7953	CLINICAL TRIALS		
101		TOTAL	-2,911,569	21,253,869

## COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET  
 I I TO 6/30/2008 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
27	CORONARY CARE UNIT	2700	
28	BURN INTENSIVE CARE UNIT	2800	
29	SURGICAL INTENSIVE CARE UNIT	2900	
31	SUBPROVIDER	3100	
33	NURSERY	3300	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
53	ELECTROCARDIOLOGY	5300	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
	SPEC PURPOSE COST CE		
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	NORTHWEST ACACEMY	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	INPATIENT SCHOOL	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	COMMUNITY RELATIONS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	CLINICAL TRIALS	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

## RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2008
144034	FROM 7/ 1/2007	WORKSHEET A-6
	TO 6/30/2008	

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 2	INCREASE	
			LINE NO 3	SALARY 4 OTHER 5
1 LEASE RECLASS	B	NEW CAP REL COSTS-BLDG & FIXT	3	175,410
2		NEW CAP REL COSTS-MVBLE EQUIP	4	107,241
3				
4				
5				
6				
7				
8				
9				
10				
11				
12 OCCUPATIONAL THERAPY	C	ADULTS & PEDIATRICS	25	162,771
13		SUBPROVIDER	31	21,498
14				3,020
15 TRANSPORTATION	H	SUBPROVIDER	31	39,749
16		CLINIC	60	6,045
17 PHYSICIAN FEES	D	SUBPROVIDER	31	74,875
18 LAB	I	LABORATORY	44	2,854
19				
20 THERAPY	J	SUBPROVIDER	31	53,207
26 TOTAL RECLASSIFICATIONS				237,476
				440,498

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.  
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

## RECLASSIFICATIONS

PROVIDER NO:

144034

PERIOD:

FROM 7/ 1/2007

TO 6/30/2008

PREPARED 11/19/2008

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 LEASE RECLASS	B	EMPLOYEE BENEFITS	5			6,850	10
2		ADMINISTRATIVE & GENERAL	6			225,230	10
3		MAINTENANCE & REPAIRS	7			1,808	10
4		SOCIAL SERVICE	18			4,299	10
5		SUBPROVIDER	31			7,597	10
6		NURSING ADMINISTRATION	14			2,261	10
7		MEDICAL RECORDS & LIBRARY	17			6,970	10
8		ADULTS & PEDIATRICS	25			11,777	10
9		CLINIC	60			7,699	10
10		COMMUNITY RELATIONS	100.02			4,994	10
11		INPATIENT SCHOOL	100.01			3,166	10
12 OCCUPATIONAL THERAPY	C	ADMINISTRATIVE & GENERAL	6		184,269	25,889	
13							
14							
15 TRANSPORTATION	H	ADMINISTRATIVE & GENERAL	6			29,103	
16		NEW CAP REL COSTS-MVBLE EQUIP	4			16,691	10
17 PHYSICIAN FEES	D	ADULTS & PEDIATRICS	25			74,875	
18 LAB	I	ADULTS & PEDIATRICS	25			2,809	
19		SUBPROVIDER	31			45	
20 THERAPY	J	ADULTS & PEDIATRICS	25		53,207	8,435	11
36 TOTAL RECLASSIFICATIONS					237,476	440,498	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.  
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

## RECLASSIFICATIONS

IN LIEU OF FORM CMS-2552-96 (09/1996)  
 PROVIDER NO: 144034 PERIOD: FROM 7/ 1/2007 TO 6/30/2008  
 PREPARED 11/19/2008  
 WORKSHEET A-6  
 NOT A CMS WORKSHEET

RECLASS CODE: B  
 EXPLANATION : LEASE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	175,410	EMPLOYEE BENEFITS	5	6,850	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	107,241	ADMINISTRATIVE & GENERAL	6	225,230	
3.00			0	MAINTENANCE & REPAIRS	7	1,808	
4.00			0	SOCIAL SERVICE	18	4,299	
5.00			0	SUBPROVIDER	31	7,597	
6.00			0	NURSING ADMINISTRATION	14	2,261	
7.00			0	MEDICAL RECORDS & LIBRARY	17	6,970	
8.00			0	ADULTS & PEDIATRICS	25	11,777	
10.00			0	CLINIC	60	7,699	
11.00			0	COMMUNITY RELATIONS	100.02	4,994	
12.00			0	INPATIENT SCHOOL	100.01	3,166	
TOTAL RECLASSIFICATIONS FOR CODE B			282,651				282,651

RECLASS CODE: C  
 EXPLANATION : OCCUPATIONAL THERAPY

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00			0	ADMINISTRATIVE & GENERAL	6	210,158	
2.00	ADULTS & PEDIATRICS	25	185,640			0	
3.00	SUBPROVIDER	31	24,518			0	
TOTAL RECLASSIFICATIONS FOR CODE C			210,158				210,158

RECLASS CODE: H  
 EXPLANATION : TRANSPORTATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	SUBPROVIDER	31	39,749	ADMINISTRATIVE & GENERAL	6	29,103	
2.00	CLINIC	60	6,045	NEW CAP REL COSTS-MVBLE EQUIP	4	16,691	
TOTAL RECLASSIFICATIONS FOR CODE H			45,794				45,794

RECLASS CODE: D  
 EXPLANATION : PHYSICIAN FEES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	SUBPROVIDER	31	74,875	ADULTS & PEDIATRICS	25	74,875	
TOTAL RECLASSIFICATIONS FOR CODE D			74,875				74,875

RECLASS CODE: I  
 EXPLANATION : LAB

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	LABORATORY	44	2,854	ADULTS & PEDIATRICS	25	2,809	
2.00			0	SUBPROVIDER	31	45	
TOTAL RECLASSIFICATIONS FOR CODE I			2,854				2,854

RECLASS CODE: J  
 EXPLANATION : THERAPY

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	SUBPROVIDER	31	61,642	ADULTS & PEDIATRICS	25	61,642	
TOTAL RECLASSIFICATIONS FOR CODE J			61,642				61,642

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES	PURCHASES	ACQUISITIONS DONATION	TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES	PURCHASES	ACQUISITIONS DONATION	TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							



PART III - RECONCILIATION OF CAPITAL COST CENTERS  
DESCRIPTION

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*		1	2	3	4	5	6	8
3	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV							
5	TOTAL				1.000000			

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	728,531	175,410					903,941
4	NEW CAP REL COSTS-MV	200,786	90,550					291,336
5	TOTAL	929,317	265,960					1,195,277

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4  
DESCRIPTION

		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	681,598						681,598
4	NEW CAP REL COSTS-MV	168,325						168,325
5	TOTAL	849,923						849,923

- \* All lines numbers except line 5 are to be consistent with workhseet A line numbers for capital cost centers.  
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.  
columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

## ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET A-8  
 I I TO 6/30/2008 I

DESCRIPTION (1)			(2)	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO	WKST.
	BASIS/CODE	AMOUNT		COST CENTER			A-7
	1	2		3		4	REF.
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	5
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	
5	INVESTMENT INCOME-OTHER						
6	TRADE, QUANTITY AND TIME DISCOUNTS						
7	REFUNDS AND REBATES OF EXPENSES						
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9	TELEPHONE SERVICES						
10	TELEVISION AND RADIO SERVICE						
11	PARKING LOT						
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-2,083,648				
13	SALE OF SCRAP, WASTE, ETC.						
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-504,980				
15	LAUNDRY AND LINEN SERVICE						
16	CAFETERIA---EMPLOYEES AND GUESTS	B	-13,768	DIETARY		11	
17	RENTAL OF QTRS TO EMPLOYEE AND OTHERS						
18	SALE OF MED AND SURG SUPPLIES						
19	SALE OF DRUGS TO OTHER THAN PATIENTS						
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-12,972	MEDICAL RECORDS & LIBRARY		17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)						
22	VENDING MACHINES	B	-3,047	MAINTENANCE & REPAIRS		7	
23	INCOME FROM IMPOSITION OF INTEREST						
24	INTRST EXP ON MEDICARE OVERPAYMENTS						
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**		49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**		50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**		89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES	A	46,933	NEW CAP REL COSTS-BLDG &		3	9
32	DEPRECIATION-NEW MOVABLE EQUIP	A	32,461	NEW CAP REL COSTS-MVBLE E		4	9
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**		20	
34	PHYSICIANS' ASSISTANT						
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**		51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**		52	
37	MISCELLANEOUS INCOME	B	-8,514	ADMINISTRATIVE & GENERAL		6	
38	PHYSICIAN BENEFITS	A	-188,577	EMPLOYEE BENEFITS		5	
38.01	PHYSICIAN BENEFITS	A	-61,111	ADULTS & PEDIATRICS		25	
38.02	PHYSICIAN BENEFITS	A	-1,605	CLINIC		60	
39	MISCELLANEOUS NON ALLOWABLE	A	-20	CLINIC		60	
40	MISCELLANEOUS NON ALLOWABLE	A	-118	EMPLOYEE BENEFITS		5	
41	MISCELLANEOUS NON ALLOWABLE	A	-95,350	ADMINISTRATIVE & GENERAL		6	
42	MISCELLANEOUS NON ALLOWABLE	A	-229	SUBPROVIDER		31	
43	OTHER ADJUSTMENTS (SPECIFY)						
44	MISCELLANEOUS NON ALLOWABLE	A	-4,812	ADULTS & PEDIATRICS		25	
44.01	TRANSPORTATION	A	-19	ADULTS & PEDIATRICS		25	
44.02	TRANSPORTATION	A	-1,102	CLINIC		60	
45	TRANSPORTATION	A	-11,091	ADMINISTRATIVE & GENERAL		6	
46	INSURANCE ADJUSTMENT	A	388,428	ADMINISTRATIVE & GENERAL		6	
46.01	INSURANCE ADJUSTMENT	A	-218,685	EMPLOYEE BENEFITS		5	
46.02	INSURANCE ADJUSTMENT	A	-169,743	ADMINISTRATIVE & GENERAL		6	
47							
48							
49	OTHER ADJUSTMENTS (SPECIFY)						
50	TOTAL (SUM OF LINES 1 THRU 49)		-2,911,569				

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7

Health Financial Systems MCRIF32  
STATEMENT OF COSTS OF SERVICES  
FROM RELATED ORGANIZATIONS AND  
HOME OFFICE COSTS

FOR STREAMWOOD

IN LIEU OF FORM CMS-2552-96(09/2000)  
I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
I 14-4034 I FROM 7/ 1/2007 I  
I I TO 6/30/2008 I WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	838,947	1,343,927	-504,980
2						
3						
4						
5		TOTALS		838,947	1,343,927	-504,980

\* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:  
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
			NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	B	0.00	ARDENT HEALTH S	100.00	HEALTHCARE
2	B	0.00	SED LAB	100.00	REFERENCE LAB
3		0.00		0.00	
4		0.00		0.00	
5		0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

- INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
- INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

## PROVIDER BASED PHYSICIAN ADJUSTMENTS

IN LIEU OF FORM CMS-2552-96(9/1996)

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET A-8-2  
 I I TO 6/30/2008 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
2 25	AGGREGATE	1,794,410	1,509,869	284,541	154,100	2,264	167,732	8,387
4 53	AGGREGATE	174,188	174,188					
5 60	AGGREGATE	207,907	207,907					
7 31	AGGREGATE	74,875	74,875					
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	2,251,380	1,966,839	284,541		2,264	167,732	8,387

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
2 25	AGGREGATE					167,732	116,809	1,626,678
4 53	AGGREGATE							174,188
5 60	AGGREGATE							207,907
7 31	AGGREGATE							74,875
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL					167,732	116,809	2,083,648

## COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET  
 I I TO 6/30/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEE T CAPITAL	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE FEE T CAPITAL	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	ENTERED
7	MAINTENANCE & REPAIRS	3	SQUARE FEE T CAPITAL	ENTERED
8	OPERATION OF PLANT	3	SQUARE FEE T CAPITAL	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	3	SQUARE FEE T CAPITAL	ENTERED
11	DIETARY	10	MEALS SERV ED	ENTERED
12	CAFETERIA	11	FTE'S	ENTERED
14	NURSING ADMINISTRATION	13	HOURS SUPE R VISED	ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	ENTERED
18	SOCIAL SERVICE	C	GROSS CHARGES	ENTERED

## COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	EMPLOYEE BENE FITS 5	SUBTOTAL 5a.00	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	903,941	903,941					
005 NEW CAP REL COSTS-MVBLE E	291,336		291,336				
006 EMPLOYEE BENEFITS	1,239,958			1,239,958			
007 ADMINISTRATIVE & GENERAL	4,269,603	198,361	63,931	197,827	4,729,722	4,729,722	
008 MAINTENANCE & REPAIRS	704,888	71,636	23,088	13,253	812,865	232,667	1,045,532
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	229,057	9,230	2,975		241,262	69,057	15,223
011 HOUSEKEEPING	240,276	3,353	1,081	693	245,403	70,242	5,530
012 DIETARY	668,308	16,339	5,266	20,741	710,654	203,411	26,947
013 CAFETERIA		21,192	6,830		28,022	8,021	34,951
014 NURSING ADMINISTRATION	1,079,476	4,463	1,438	82,042	1,167,419	334,152	7,360
017 MEDICAL RECORDS & LIBRARY	506,416	9,352	3,014	15,751	534,533	153,000	15,424
018 SOCIAL SERVICE	1,093,309			84,735	1,178,044	337,193	
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	6,500,224	462,409	149,033	625,739	7,737,405	2,214,683	762,627
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
031 SURGICAL INTENSIVE CARE U							
033 SUBPROVIDER	908,675	46,152	14,875	65,810	1,035,512	296,396	76,116
035 NURSERY							
041 NURSING FACILITY							
044 ANCILLARY SRVC COST CNTRS							
053 RADIOLOGY-DIAGNOSTIC							
056 LABORATORY	69,940				69,940	20,019	
060 ELECTROCARDIOLOGY	255,421	3,219	1,037	10,577	270,254	77,355	5,309
095 DRUGS CHARGED TO PATIENTS	830,832	3,768	1,214		835,814	239,236	6,214
098 OUTPAT SERVICE COST CNTRS							
100 CLINIC	710,039	44,798	14,438	71,261	840,536	240,587	73,884
101 SPEC PURPOSE COST CENTERS							
102 SUBTOTALS	20,501,699	894,272	288,220	1,188,429	20,437,385	4,496,019	1,029,585
103 NONREIMBURS COST CENTERS							
100 PHYSICIANS' PRIVATE OFFIC							
100 NORTHWEST ACACEMY							
100 01 INPATIENT SCHOOL	314,853	9,023	2,908	24,159	350,943	100,451	14,881
100 02 COMMUNITY RELATIONS	437,317	646	208	27,370	465,541	133,252	1,066
100 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	21,253,869	903,941	291,336	1,239,958	21,253,869	4,729,722	1,045,532

## COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT 8	LAUNDRY & LIN EN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMIN ISTRATION 14	MEDICAL RECOR DS & LIBRARY 17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE		325,542					
011 HOUSEKEEPING		13,261	334,436				
012 DIETARY		13,261	8,794	963,067			
014 CAFETERIA			11,406	95,142	177,542		
017 NURSING ADMINISTRATION			2,402		9,874	1,521,207	
018 MEDICAL RECORDS & LIBRARY			5,034		3,645		711,636
018 SOCIAL SERVICE					15,613		
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		264,134	248,882	739,706	111,086	1,236,071	611,664
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
031 SURGICAL INTENSIVE CARE U							
033 SUBPROVIDER		34,886	24,840	97,076	15,490	172,389	35,316
035 NURSERY							
041 NURSING FACILITY							
044 ANCILLARY SRVC COST CNTRS							
053 RADIOLOGY-DIAGNOSTIC							2,846
056 LABORATORY							6,984
060 ELECTROCARDIOLOGY			1,733		2,690		20,807
095 DRUGS CHARGED TO PATIENTS			2,028				
098 OUTPAT SERVICE COST CNTRS							
100 CLINIC			24,112	31,143	10,137	112,747	34,019
101 SPEC PURPOSE COST CENTERS							
102 SUBTOTALS		325,542	329,231	963,067	168,535	1,521,207	711,636
103 NONREIMBURS COST CENTERS							
100 PHYSICIANS' PRIVATE OFFIC							
100 NORTHWEST ACADAMY							
100 01 INPATIENT SCHOOL			4,857		4,845		
100 02 COMMUNITY RELATIONS			348		4,162		
100 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL		325,542	334,436	963,067	177,542	1,521,207	711,636

## COST ALLOCATION - GENERAL SERVICE COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET B
I		I	TO 6/30/2008	I	PART I

COST CENTER DESCRIPTION		SOCIAL SERVIC E	18	25	I&R COST POST STEP- DOWN ADJ 26	TOTAL 27
GENERAL SERVICE COST CNTR						
003	NEW CAP REL COSTS-BLDG &					
004	NEW CAP REL COSTS-MVBLE E					
005	EMPLOYEE BENEFITS					
006	ADMINISTRATIVE & GENERAL					
007	MAINTENANCE & REPAIRS					
008	OPERATION OF PLANT					
009	LAUNDRY & LINEN SERVICE					
010	HOUSEKEEPING					
011	DIETARY					
012	CAFETERIA					
014	NURSING ADMINISTRATION					
017	MEDICAL RECORDS & LIBRARY					
018	SOCIAL SERVICE	1,530,850				
	INPAT ROUTINE SRVC CNTRS					
025	ADULTS & PEDIATRICS	1,315,793	15,242,051			15,242,051
026	INTENSIVE CARE UNIT					
027	CORONARY CARE UNIT					
028	BURN INTENSIVE CARE UNIT					
029	SURGICAL INTENSIVE CARE U					
031	SUBPROVIDER	75,971	1,863,992			1,863,992
033	NURSERY					
035	NURSING FACILITY					
	ANCILLARY SRVC COST CNTRS					
041	RADIOLOGY-DIAGNOSTIC					
044	LABORATORY	6,122	98,927			98,927
053	ELECTROCARDIOLOGY	15,024	379,349			379,349
056	DRUGS CHARGED TO PATIENTS	44,759	1,148,858			1,148,858
	OUTPAT SERVICE COST CNTRS					
060	CLINIC	73,181	1,440,346			1,440,346
	SPEC PURPOSE COST CENTERS					
095	SUBTOTALS	1,530,850	20,173,523			20,173,523
	NONREIMBURS COST CENTERS					
098	PHYSICIANS' PRIVATE OFFIC					
100	NORTHWEST ACACEMY					
100	01 INPATIENT SCHOOL		475,977			475,977
100	02 COMMUNITY RELATIONS		604,369			604,369
100	03 CLINICAL TRIALS					
101	CROSS FOOT ADJUSTMENT					
102	NEGATIVE COST CENTER					
103	TOTAL	1,530,850	21,253,869			21,253,869



## ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS	61,110	198,361	63,931	323,402		323,402	
007 ADMINISTRATIVE & GENERAL		71,636	23,088	94,724		15,909	110,633
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE		9,230	2,975	12,205		4,722	1,611
011 HOUSEKEEPING		3,353	1,081	4,434		4,803	585
012 DIETARY		16,339	5,266	21,605		13,908	2,851
014 CAFETERIA		21,192	6,830	28,022		548	3,698
017 NURSING ADMINISTRATION		4,463	1,438	5,901		22,848	779
018 MEDICAL RECORDS & LIBRARY		9,352	3,014	12,366		10,461	1,632
025 SOCIAL SERVICE						23,055	
026 INPAT ROUTINE SRVC CNTRS		462,409	149,033	611,442		151,437	80,697
027 ADULTS & PEDIATRICS							
028 INTENSIVE CARE UNIT							
029 CORONARY CARE UNIT							
031 BURN INTENSIVE CARE UNIT							
033 SURGICAL INTENSIVE CARE U		46,152	14,875	61,027		20,266	8,054
035 SUBPROVIDER							
041 NURSERY							
044 NURSING FACILITY							
053 ANCILLARY SRVC COST CNTRS							
056 RADIOLOGY-DIAGNOSTIC							
060 LABORATORY						1,369	
095 ELECTROCARDIOLOGY		3,219	1,037	4,256		5,289	562
098 DRUGS CHARGED TO PATIENTS		3,768	1,214	4,982		16,358	658
100 OUTPAT SERVICE COST CNTRS							
101 CLINIC		44,798	14,438	59,236		16,450	7,818
102 SPEC PURPOSE COST CENTERS							
103 SUBTOTALS	61,110	894,272	288,220	1,243,602		307,423	108,945
098 NONREIMBURS COST CENTERS							
100 PHYSICIANS' PRIVATE OFFIC							
100 NORTHWEST ACADAMY							
100 01 INPATIENT SCHOOL		9,023	2,908	11,931		6,868	1,575
100 02 COMMUNITY RELATIONS		646	208	854		9,111	113
100 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	61,110	903,941	291,336	1,256,387		323,402	110,633

## ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

	COST CENTER DESCRIPTION	OPERATION OF PLANT 8	LAUNDRY & LIN EN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMIN ISTRATION 14	MEDICAL RECOR DS & LIBRARY 17
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
007	ADMINISTRATIVE & GENERAL							
008	MAINTENANCE & REPAIRS							
009	OPERATION OF PLANT							
010	LAUNDRY & LINEN SERVICE		18,538					
011	HOUSEKEEPING		755	10,577				
012	DIETARY		755	278	39,397			
014	CAFETERIA			361	3,892	36,521		
017	NURSING ADMINISTRATION			76		2,031	31,635	
018	MEDICAL RECORDS & LIBRARY			159		750		25,368
025	SOCIAL SERVICE					3,212		
026	INPAT ROUTINE SRVC CNTRS							
027	ADULTS & PEDIATRICS		15,041	7,870	30,260	22,851	25,705	21,804
028	INTENSIVE CARE UNIT							
029	CORONARY CARE UNIT							
031	BURN INTENSIVE CARE UNIT							
033	SURGICAL INTENSIVE CARE U							
035	SUBPROVIDER		1,987	786	3,971	3,186	3,585	1,259
041	NURSERY							
044	NURSING FACILITY							
053	ANCILLARY SRVC COST CNTRS							
056	RADIOLOGY-DIAGNOSTIC							
060	LABORATORY							101
095	ELECTROCARDIOLOGY			55		553		249
098	DRUGS CHARGED TO PATIENTS			64				742
100	OUTPAT SERVICE COST CNTRS							
101	CLINIC			763	1,274	2,085	2,345	1,213
102	SPEC PURPOSE COST CENTERS							
103	SUBTOTALS		18,538	10,412	39,397	34,668	31,635	25,368
104	NONREIMBURS COST CENTERS							
105	PHYSICIANS' PRIVATE OFFIC							
106	NORTHWEST ACADAMY							
107	01 INPATIENT SCHOOL			154		997		
108	02 COMMUNITY RELATIONS			11		856		
109	03 CLINICAL TRIALS							
110	CROSS FOOT ADJUSTMENTS							
111	NEGATIVE COST CENTER							
112	TOTAL		18,538	10,577	39,397	36,521	31,635	25,368

## ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

	COST CENTER DESCRIPTION	SOCIAL SERVIC E	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		18	25	26	27
003	GENERAL SERVICE COST CNTR				
004	NEW CAP REL COSTS-BLDG &				
005	NEW CAP REL COSTS-MVBLE E				
006	EMPLOYEE BENEFITS				
007	ADMINISTRATIVE & GENERAL				
008	MAINTENANCE & REPAIRS				
009	OPERATION OF PLANT				
010	LAUNDRY & LINEN SERVICE				
011	HOUSEKEEPING				
012	DIETARY				
014	CAFETERIA				
017	NURSING ADMINISTRATION				
018	MEDICAL RECORDS & LIBRARY				
	SOCIAL SERVICE	26,267			
025	INPAT ROUTINE SRVC CNTRS				
026	ADULTS & PEDIATRICS	22,578	989,685		989,685
027	INTENSIVE CARE UNIT				
028	CORONARY CARE UNIT				
029	BURN INTENSIVE CARE UNIT				
031	SURGICAL INTENSIVE CARE U				
033	SUBPROVIDER	1,303	105,424		105,424
035	NURSEY				
	NURSING FACILITY				
041	ANCILLARY SRVC COST CNTRS				
044	RADIOLOGY-DIAGNOSTIC				
053	LABORATORY	105	1,575		1,575
056	ELECTROCARDIOLOGY	258	11,222		11,222
	DRUGS CHARGED TO PATIENTS	768	23,572		23,572
060	OUTPAT SERVICE COST CNTRS				
	CLINIC	1,255	92,439		92,439
095	SPEC PURPOSE COST CENTERS				
	SUBTOTALS	26,267	1,223,917		1,223,917
098	NONREIMBURS COST CENTERS				
100	PHYSICIANS' PRIVATE OFFIC				
100	NORTHWEST ACADAMY				
100	01 INPATIENT SCHOOL		21,525		21,525
100	02 COMMUNITY RELATIONS		10,945		10,945
100	03 CLINICAL TRIALS				
101	CROSS FOOT ADJUSTMENTS				
102	NEGATIVE COST CENTER				
103	TOTAL	26,267	1,256,387		1,256,387

## COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

	COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
		(SQUARE FEE T CAPITAL	(SQUARE FEE T CAPITAL	( GROSS SALARIES )		( ACCUM. COST	(SQUARE FEE T CAPITAL )
		3	4	5	6a.00	6	7
003	GENERAL SERVICE COST						
004	NEW CAP REL COSTS-BLD	74,134					
005	NEW CAP REL COSTS-MVB		74,134				
006	EMPLOYEE BENEFITS			14,555,559			
007	ADMINISTRATIVE & GENE	16,268	16,268	2,322,241	-4,729,722	16,524,147	
008	MAINTENANCE & REPAIRS	5,875	5,875	155,571		812,865	51,991
009	OPERATION OF PLANT						
010	LAUNDRY & LINEN SERVI	757	757			241,262	757
011	HOUSEKEEPING	275	275	8,136		245,403	275
012	DIETARY	1,340	1,340	243,479		710,654	1,340
014	CAFETERIA	1,738	1,738			28,022	1,738
017	NURSING ADMINISTRATIO	366	366	963,073		1,167,419	366
018	MEDICAL RECORDS & LIB	767	767	184,899		534,533	767
	SOCIAL SERVICE			994,686		1,178,044	
025	INPAT ROUTINE SRVC CN						
026	ADULTS & PEDIATRICS	37,923	37,923	7,345,382		7,737,405	37,923
027	INTENSIVE CARE UNIT						
028	CORONARY CARE UNIT						
029	BURN INTENSIVE CARE U						
031	SURGICAL INTENSIVE CA	3,785	3,785	772,531		1,035,512	3,785
033	SUBPROVIDER						
035	NURSERY						
	NURSING FACILITY						
041	ANCILLARY SRVC COST C						
044	RADIOLOGY-DIAGNOSTIC					69,940	
053	LABORATORY	264	264	124,162		270,254	264
056	ELECTROCARDIOLOGY	309	309			835,814	309
	DRUGS CHARGED TO PATI						
060	OUTPAT SERVICE COST C	3,674	3,674	836,513		840,536	3,674
	CLINIC						
095	SPEC PURPOSE COST CEN						
	SUBTOTALS	73,341	73,341	13,950,673	-4,729,722	15,707,663	51,198
098	NONREIMBURS COST CENT						
100	PHYSICIANS' PRIVATE O						
100	NORTHWEST ACACEMY						
100	01 INPATIENT SCHOOL	740	740	283,597		350,943	740
100	02 COMMUNITY RELATIONS	53	53	321,289		465,541	53
100	03 CLINICAL TRIALS						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED	903,941	291,336	1,239,958		4,729,722	1,045,532
	(WRKSHT B, PART I)						
104	UNIT COST MULTIPLIER	12.193339		.085188		.286231	
	(WRKSHT B, PT I)		3.929857				20.109865
105	COST TO BE ALLOCATED						
	(WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER						
	(WRKSHT B, PT II)						
107	COST TO BE ALLOCATED					323,402	110,633
	(WRKSHT B, PART III)						
108	UNIT COST MULTIPLIER					.019571	
	(WRKSHT B, PT III)						2.127926

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

## COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	OPERATION OF PLANT (SQUARE FEET CAPITAL)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET CAPITAL)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS SUPERVISED)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	51,991						
010 LAUNDRY & LINEN SERVICE	757	76,594					
011 HOUSEKEEPING	275		50,959				
012 DIETARY	1,340	3,120	1,340	148,931			
014 CAFETERIA	1,738		1,738	14,713	20,264		
017 NURSING ADMINISTRATION	366		366		1,127	324,556	
018 MEDICAL RECORDS & LIBRARY	767		767		416		51,474,526
018 SOCIAL SERVICE					1,782		
025 INPAT ROUTINE SRVC CN							
026 ADULTS & PEDIATRICS	37,923	62,146	37,923	114,390	12,679	263,721	44,243,312
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE U							
031 SURGICAL INTENSIVE CA							
033 SUBPROVIDER	3,785	8,208	3,785	15,012	1,768	36,780	2,554,499
035 NURSERY							
041 NURSING FACILITY							
044 ANCILLARY SRVC COST C							
053 RADIOLOGY-DIAGNOSTIC							205,836
056 LABORATORY							505,190
060 ELECTROCARDIOLOGY	264		264		307		1,505,013
095 DRUGS CHARGED TO PATI	309		309				
104 OUTPAT SERVICE COST C							
106 CLINIC	3,674		3,674	4,816	1,157	24,055	2,460,676
107 SPEC PURPOSE COST CEN							
108 SUBTOTALS	51,198	76,594	50,166	148,931	19,236	324,556	51,474,526
098 NONREIMBURS COST CENT							
100 PHYSICIANS' PRIVATE O							
100 NORTHWEST ACADAMY							
100 01 INPATIENT SCHOOL	740		740		553		
100 02 COMMUNITY RELATIONS	53		53		475		
100 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED		325,542	334,436	963,067	177,542	1,521,207	711,636
104 (WRKSHT B, PART I)							
105 UNIT COST MULTIPLIER		4.250228		6.466531		4.687040	
106 (WRKSHT B, PT I)			6.562845		8.761449		.013825
107 COST TO BE ALLOCATED							
108 (WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
107 (WRKSHT B, PT II)							
108 COST TO BE ALLOCATED		18,538	10,577	39,397	36,521	31,635	25,368
106 (WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER		.242029		.264532		.097472	
106 (WRKSHT B, PT III)			.207559		1.802260		.000493

## COST ALLOCATION - STATISTICAL BASIS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET B-1
I		I	TO 6/30/2008	I	

COST CENTER DESCRIPTION		SOCIAL SERVIC E
		( GROSS CHARGES )
		18
003	GENERAL SERVICE COST	
004	NEW CAP REL COSTS-BLD	
005	NEW CAP REL COSTS-MVB	
006	EMPLOYEE BENEFITS	
007	ADMINISTRATIVE & GENE	
008	MAINTENANCE & REPAIRS	
009	OPERATION OF PLANT	
010	LAUNDRY & LINEN SERVI	
011	HOUSEKEEPING	
012	DIETARY	
014	CAFETERIA	
017	NURSING ADMINISTRATIO	
018	MEDICAL RECORDS & LIB	
025	SOCIAL SERVICE	51,474,526
026	INPAT ROUTINE SRVC CN	
027	ADULTS & PEDIATRICS	44,243,312
028	INTENSIVE CARE UNIT	
029	CORONARY CARE UNIT	
031	BURN INTENSIVE CARE U	
033	SURGICAL INTENSIVE CA	
035	SUBPROVIDER	2,554,499
041	NURSERY	
044	NURSING FACILITY	
053	ANCILLARY SRVC COST C	
056	RADIOLOGY-DIAGNOSTIC	
060	LABORATORY	205,836
095	ELECTROCARDIOLOGY	505,190
098	DRUGS CHARGED TO PATI	1,505,013
100	OUTPAT SERVICE COST C	
100 01	CLINIC	2,460,676
100 02	SPEC PURPOSE COST CEN	
100 03	SUBTOTALS	51,474,526
101	NONREIMBURS COST CENT	
102	PHYSICIANS' PRIVATE O	
103	NORTHWEST ACACEMY	
104	01 INPATIENT SCHOOL	
105	02 COMMUNITY RELATIONS	
106	03 CLINICAL TRIALS	
107	CROSS FOOT ADJUSTMENT	
108	NEGATIVE COST CENTER	
	COST TO BE ALLOCATED	1,530,850
	(PER WRKSHT B, PART	
	UNIT COST MULTIPLIER	
	(WRKSHT B, PT I)	.029740
	COST TO BE ALLOCATED	
	(PER WRKSHT B, PART	
	UNIT COST MULTIPLIER	
	(WRKSHT B, PT II)	
	COST TO BE ALLOCATED	26,267
	(PER WRKSHT B, PART	
	UNIT COST MULTIPLIER	
	(WRKSHT B, PT III)	.000510

## COMPUTATION OF RATIO OF COSTS TO CHARGES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET C
I		I	TO 6/30/2008	I	PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	15,242,051		15,242,051		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER	1,863,992		1,863,992		
33	NURSERY					
35	NURSING FACILITY					
41	ANCILLARY SRVC COST CNTRS					
44	RADIOLOGY-DIAGNOSTIC					
	LABORATORY	98,927		98,927		
53	ELECTROCARDIOLOGY	379,349		379,349		
56	DRUGS CHARGED TO PATIENTS	1,148,858		1,148,858		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	1,440,346		1,440,346		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	20,173,523		20,173,523		
102	LESS OBSERVATION BEDS					
103	TOTAL	20,173,523		20,173,523		

## COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	44,243,312		44,243,312			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER	2,554,499		2,554,499			
33	NURSERY						
35	NURSING FACILITY						
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
	LABORATORY	205,671	165	205,836	.480611	.480611	
53	ELECTROCARDIOLOGY	502,400	2,790	505,190	.750904	.750904	
56	DRUGS CHARGED TO PATIENTS	1,505,013		1,505,013	.763354	.763354	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		2,460,676	2,460,676	.585346	.585346	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	49,010,895	2,463,631	51,474,526			
102	LESS OBSERVATION BEDS						
103	TOTAL	49,010,895	2,463,631	51,474,526			



COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET C
I		I	TO 6/30/2008	I	PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
26	ADULTS & PEDIATRICS	15,242,051		15,242,051		
27	INTENSIVE CARE UNIT					
28	CORONARY CARE UNIT					
29	BURN INTENSIVE CARE UNIT					
31	SURGICAL INTENSIVE CARE U					
33	SUBPROVIDER	1,863,992		1,863,992		
35	NURSERY					
	NURSING FACILITY					
41	ANCILLARY SRVC COST CNTRS					
44	RADIOLOGY-DIAGNOSTIC					
53	LABORATORY	98,927		98,927		
56	ELECTROCARDIOLOGY	379,349		379,349		
60	DRUGS CHARGED TO PATIENTS	1,148,858		1,148,858		
	OUTPAT SERVICE COST CNTRS					
101	CLINIC	1,440,346		1,440,346		
102	OTHER REIMBURS COST CNTRS					
103	SUBTOTAL	20,173,523		20,173,523		
	LESS OBSERVATION BEDS					
	TOTAL	20,173,523		20,173,523		

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET C
I		I	TO 6/30/2008	I	PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	44,243,312		44,243,312			
27	INTENSIVE CARE UNIT						
28	CORONARY CARE UNIT						
29	BURN INTENSIVE CARE UNIT						
31	SURGICAL INTENSIVE CARE U						
33	SUBPROVIDER	2,554,499		2,554,499			
35	NURSERY						
41	NURSING FACILITY						
44	ANCILLARY SRVC COST CNTRS						
53	RADIOLOGY-DIAGNOSTIC						
56	LABORATORY	205,671	165	205,836	.480611	.480611	
60	ELECTROCARDIOLOGY	502,400	2,790	505,190	.750904	.750904	
101	DRUGS CHARGED TO PATIENTS	1,505,013		1,505,013	.763354	.763354	
102	OUTPAT SERVICE COST CNTRS						
103	CLINIC		2,460,676	2,460,676	.585346	.585346	
	OTHER REIMBURS COST CNTRS						
	SUBTOTAL	49,010,895	2,463,631	51,474,526			
	LESS OBSERVATION BEDS						
	TOTAL	49,010,895	2,463,631	51,474,526			

Health Financial Systems MCRIF32 FOR STREAMWOOD  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS

IN LIEU OF FORM CMS-2552-96(09/2000)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY	98,927	1,575	97,352			98,927
56	ELECTROCARDIOLOGY	379,349	11,222	368,127			379,349
60	DRUGS CHARGED TO PATIENTS	1,148,858	23,572	1,125,286			1,148,858
	OUTPAT SERVICE COST CNTRS						
	CLINIC	1,440,346	92,439	1,347,907			1,440,346
101	OTHER REIMBURS COST CNTRS						
102	SUBTOTAL	3,067,480	128,808	2,938,672			3,067,480
103	LESS OBSERVATION BEDS						
	TOTAL	3,067,480	128,808	2,938,672			3,067,480

Health Financial Systems MCRIF32 FOR STREAMWOOD  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS

IN LIEU OF FORM CMS-2552-96(09/2000)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY	205,836	.480611	.480611
53	ELECTROCARDIOLOGY	505,190	.750904	.750904
56	DRUGS CHARGED TO PATIENTS	1,505,013	.763354	.763354
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2,460,676	.585346	.585346
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	4,676,715		
102	LESS OBSERVATION BEDS			
103	TOTAL	4,676,715		

Health Financial Systems MCRIF32 FOR STREAMWOOD  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS  
 SPECIAL TITLE XIX WORKSHEET

\*\*NOT A CMS WORKSHEET \*\* (09/2000)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY	98,927	1,575	97,352	158	5,646	93,123
56	ELECTROCARDIOLOGY	379,349	11,222	368,127	1,122	21,351	356,876
60	DRUGS CHARGED TO PATIENTS	1,148,858	23,572	1,125,286	2,357	65,267	1,081,234
	OUTPAT SERVICE COST CNTRS						
	CLINIC	1,440,346	92,439	1,347,907	9,244	78,179	1,352,923
101	OTHER REIMBURS COST CNTRS						
102	SUBTOTAL	3,067,480	128,808	2,938,672	12,881	170,443	2,884,156
103	LESS OBSERVATION BEDS						
	TOTAL	3,067,480	128,808	2,938,672	12,881	170,443	2,884,156

Health Financial Systems MCRIF32 FOR STREAMWOOD  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS  
 SPECIAL TITLE XIX WORKSHEET

\*\*NOT A CMS WORKSHEET \*\* (09/2000)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS			
44	RADIOLOGY-DIAGNOSTIC			
53	LABORATORY	205,836	.452414	.479843
56	ELECTROCARDIOLOGY	505,190	.706419	.748683
	DRUGS CHARGED TO PATIENTS	1,505,013	.718422	.761788
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2,460,676	.549818	.581589
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	4,676,715		
102	LESS OBSERVATION BEDS			
103	TOTAL	4,676,715		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET D  
 I I TO 6/30/2008 I PART I

TITLE XVIII, PART A

TEFRA

WKST A	COST CENTER DESCRIPTION	CAPITAL REL COST (B, II) 1	OLD CAPITAL SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	NEW CAPITAL SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS				989,685		989,685
26	ADULTS & PEDIATRICS						
27	INTENSIVE CARE UNIT						
28	CORONARY CARE UNIT						
29	BURN INTENSIVE CARE UNIT						
31	SURGICAL INTENSIVE CARE U						
33	SUBPROVIDER				105,424		105,424
101	NURSERY						
	TOTAL				1,095,109		1,095,109

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET D  
 I I TO 6/30/2008 I PART I

TITLE XVIII, PART A

TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	37,888				26.12	
27	INTENSIVE CARE UNIT						
28	CORONARY CARE UNIT						
29	BURN INTENSIVE CARE UNIT						
31	SURGICAL INTENSIVE CARE U						
33	SUBPROVIDER	5,004				21.07	
101	NURSERY						
	TOTAL	42,892					



APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XVIII, PART AIN LIEU OF FORM CMS-2552-96(11/1998)  
I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
I 14-4034 I FROM 7/ 1/2007 I WORKSHEET D  
I I TO 6/30/2008 I PART III  
TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS					37,888	
27	INTENSIVE CARE UNIT						
28	CORONARY CARE UNIT						
29	BURN INTENSIVE CARE UNIT						
31	SURGICAL INTENSIVE CARE U						
33	SUBPROVIDER					5,004	
35	NURSERY						
101	NURSING FACILITY						
	TOTAL					42,892	

APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XVIII, PART A

IN LIEU OF FORM CMS-2552-96(11/1998)

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D
I		I	TO 6/30/2008	I	PART III

WKST A	COST CENTER DESCRIPTION	INPATIENT	INPAT PROGRAM
LINE NO.		PROG DAYS	PASS THRU COST
		7	8
25	ADULTS & PEDIATRICS		
26	INTENSIVE CARE UNIT		
27	CORONARY CARE UNIT		
28	BURN INTENSIVE CARE UNIT		
29	SURGICAL INTENSIVE CARE U		
31	SUBPROVIDER		
33	NURSERY		
35	NURSING FACILITY		
101	TOTAL		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D
I		I	TO 6/30/2008	I	PART I

TITLE XIX

TEFRA

WKST A	COST CENTER DESCRIPTION	CAPITAL REL	OLD CAPITAL	REDUCED CAP	CAPITAL REL	NEW CAPITAL	REDUCED CAP
LINE NO.		COST (B, II)	SWING BED	RELATED COST	COST (B, III)	SWING BED	RELATED COST
		1	ADJUSTMENT	3	4	ADJUSTMENT	6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS				989,685		989,685
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER				105,424		105,424
33	NURSERY						
101	TOTAL				1,095,109		1,095,109

## APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
I 14-4034 I FROM 7/ 1/2007 I WORKSHEET D  
I I TO 6/30/2008 I PART I

## TITLE XIX

TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	37,888	29,481			26.12	770,044
27	INTENSIVE CARE UNIT						
28	CORONARY CARE UNIT						
29	BURN INTENSIVE CARE UNIT						
31	SURGICAL INTENSIVE CARE U						
33	SUBPROVIDER	5,004				21.07	
101	NURSERY						
	TOTAL	42,892	29,481				770,044

TITLE XIX		HOSPITAL		TEFRA			
WKST A	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST	NEW CAPITAL RELATED COST	TOTAL CHARGES	INPAT PROGRAM CHARGES	OLD CAPITAL CST/CHRG RATIO	CAPITAL COSTS
LINE NO.		1	2	3	4	5	6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY		1,575	205,836	158,766		
53	ELECTROCARDIOLOGY		11,222	505,190	392,490		
56	DRUGS CHARGED TO PATIENTS		23,572	1,505,013	1,165,908		
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		92,439	2,460,676			
	OTHER REIMBURS COST CNTRS						
101	TOTAL		128,808	4,676,715	1,717,164		

TITLE XIX		HOSPITAL	
WKST A LINE NO.	COST CENTER DESCRIPTION	NEW CAPITAL	
		CST/CHRG 7	RATIO 8
41	ANCILLARY SRVC COST CNTRS		
44	RADIOLOGY-DIAGNOSTIC		
53	LABORATORY	.007652	1,215
56	ELECTROCARDIOLOGY	.022213	8,718
60	DRUGS CHARGED TO PATIENTS	.015662	18,260
	OUTPAT SERVICE COST CNTRS		
	CLINIC	.037567	
101	OTHER REIMBURS COST CNTRS		
	TOTAL		28,193

APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XIX

IN LIEU OF FORM CMS-2552-96(11/1998)  
I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
I 14-4034 I FROM 7/ 1/2007 I WORKSHEET D  
I I TO 6/30/2008 I PART III  
TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS					37,888	
26	ADULTS & PEDIATRICS						
27	INTENSIVE CARE UNIT						
28	CORONARY CARE UNIT						
29	BURN INTENSIVE CARE UNIT						
31	SURGICAL INTENSIVE CARE U						
33	SUBPROVIDER					5,004	
35	NURSERY						
101	NURSING FACILITY						
	TOTAL					42,892	

Health Financial Systems      MCRIF32      FOR STREAMWOOD

APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XIX

IN LIEU OF FORM CMS-2552-96(11/1998)

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D
I		I	TO 6/30/2008	I	PART III

WKST A	COST CENTER DESCRIPTION	INPATIENT	INPAT PROGRAM
LINE NO.		PROG DAYS	PASS THRU COST
		7	8
25	ADULTS & PEDIATRICS	29,481	
26	INTENSIVE CARE UNIT		
27	CORONARY CARE UNIT		
28	BURN INTENSIVE CARE UNIT		
29	SURGICAL INTENSIVE CARE U		
31	SUBPROVIDER		
33	NURSERY		
35	NURSING FACILITY		
101	TOTAL	29,481	



I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART IV  
 I 14-4034 I I

TITLE XIX

HOSPITAL

TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY						
56	ELECTROCARDIOLOGY						
	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

TITLE XIX		HOSPITAL		TEFRA				
WKST A	COST CENTER DESCRIPTION	TOTAL	O/P PASS THRU	TOTAL	RATIO OF COST	O/P RATIO OF	INPAT PROG	INPAT PROG
LINE NO.		COSTS	COSTS	CHARGES	TO CHARGES	CST TO CHARGES	CHARGE	PASS THRU COST
		3	3.01	4	5	5.01	6	7
41	ANCILLARY SRVC COST CNTRS							
44	RADIOLOGY-DIAGNOSTIC			205,836			158,766	
53	LABORATORY			505,190			392,490	
56	ELECTROCARDIOLOGY			1,505,013			1,165,908	
	DRUGS CHARGED TO PATIENTS							
60	OUTPAT SERVICE COST CNTRS			2,460,676				
	CLINIC							
101	OTHER REIMBURS COST CNTRS			4,676,715			1,717,164	
	TOTAL							

TITLE XIX

HOSPITAL

TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY						
56	ELECTROCARDIOLOGY						
	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL		1,238,017				

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D
I	COMPONENT NO:	I	TO 6/30/2008	I	PART V
I	14-4034	I		I	

TITLE XIX - O/P

HOSPITAL

	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All other (1)
Cost Center Description	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY	.452414				
53 ELECTROCARDIOLOGY	.706419				
56 DRUGS CHARGED TO PATIENTS	.718422				
60 OUTPAT SERVICE COST CNTRS					
CLINIC	.549818				1,238,017
101 SUBTOTAL					1,238,017
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					1,238,017

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D
I	COMPONENT NO:	I	TO 6/30/2008	I	PART V
I	14-4034	I		I	

TITLE XIX - O/P

HOSPITAL

PPS Services  
FYB to 12/31Non-PPS  
ServicesPPS Services  
1/1 to FYEOutpatient  
Ambulatory  
Surgical CtrOutpatient  
Radiology

Cost Center Description

5.01

5.02

5.03

6

7

(A) ANCILLARY SRVC COST CNTRS  
 41 RADIOLOGY-DIAGNOSTIC  
 44 LABORATORY  
 53 ELECTROCARDIOLOGY  
 56 DRUGS CHARGED TO PATIENTS  
 OUTPAT SERVICE COST CNTRS  
 60 CLINIC  
 101 SUBTOTAL  
 102 CRNA CHARGES  
 103 LESS PBP CLINIC LAB SVCS--  
 PROGRAM ONLY CHARGES  
 104 NET CHARGES

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2008  
 I 14-4034 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-4034 I I

TITLE XIX - O/P

HOSPITAL

		Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
Cost Center Description		8	9	9.01	9.02	9.03
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
53	ELECTROCARDIOLOGY					
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		680,684			
101	SUBTOTAL		680,684			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		680,684			

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART I
I	14-4034	I		I	

TITLE XVIII PART A

HOSPITAL

TEFRA

## PART I - ALL PROVIDER COMPONENTS

1

## INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	37,888
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	37,888
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	37,888
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

## SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	15,242,051
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	15,242,051

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	43,639,103
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	43,639,103
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.349275
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,151.79
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	15,242,051

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART II
I	14-4034	I		I	

## TITLE XVIII PART A

## HOSPITAL

## TEFRA

## PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	402.29
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT				
	HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

## PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

## TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES	7,716.16
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	

## PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS



## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART III
I	14-4034	I		I	

TITLE XVIII PART A

HOSPITAL

TEFRA

## PART III - SKILLED NURSING FACILITY, NURSING FACILITY &amp; ICF/MR ONLY

1

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE  
SERVICE COST  
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM  
68 PROGRAM ROUTINE SERVICE COST  
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM  
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS  
71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS  
72 PER DIEM CAPITAL-RELATED COSTS  
73 PROGRAM CAPITAL-RELATED COSTS  
74 INPATIENT ROUTINE SERVICE COST  
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS  
76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION  
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION  
78 INPATIENT ROUTINE SERVICE COST LIMITATION  
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS  
80 PROGRAM INPATIENT ANCILLARY SERVICES  
81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION  
82 TOTAL PROGRAM INPATIENT OPERATING COSTS

## PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	402.29
85	OBSERVATION BED COST	

## COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		15,242,051			
87 NEW CAPITAL-RELATED COST	989,685	15,242,051	.064931		
88 NON PHYSICIAN ANESTHETIST		15,242,051			
89 MEDICAL EDUCATION		15,242,051			
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART I
I	-	I		I	

TITLE XVIII PART A

SUBPROVIDER I

TEFRA

## PART I - ALL PROVIDER COMPONENTS

1

## INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,004
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,004
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,004
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

## SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,569,326
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,569,326
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	513.45
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

## COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO:	I PERIOD:	I PREPARED 11/19/2008
I 14-4034	I FROM 7/ 1/2007	I WORKSHEET D-1
I COMPONENT NO:	I TO 6/30/2008	I PART II
I -	I	I

TITLE XVIII PART A

SUBPROVIDER I

TEFRA

## PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM  
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST  
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT					
HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					

1

48 PROGRAM INPATIENT ANCILLARY SERVICE COST  
49 TOTAL PROGRAM INPATIENT COSTS

## PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES  
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES  
52 TOTAL PROGRAM EXCLUDABLE COST  
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN  
ANESTHETIST, AND MEDICAL EDUCATION COSTS

## TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES	
55 TARGET AMOUNT PER DISCHARGE	
56 TARGET AMOUNT	12,322,708
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	6
58 BONUS PAYMENT	
58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04 RELIEF PAYMENT	
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	13,120,940
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03 PROGRAM DISCHARGES AFTER JULY 1	
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	

## PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST  
REPORTING PERIOD (SEE INSTRUCTIONS)  
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST  
REPORTING PERIOD (SEE INSTRUCTIONS)  
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS  
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE  
COST REPORTING PERIOD  
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE  
COST REPORTING PERIOD  
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART III
I	-	I		I	

TITLE XVIII PART A

SUBPROVIDER I

TEFRA

## PART III - SKILLED NURSING FACILITY, NURSING FACILITY &amp; ICF/MR ONLY

1

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE  
SERVICE COST  
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM  
68 PROGRAM ROUTINE SERVICE COST  
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM  
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS  
71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS  
72 PER DIEM CAPITAL-RELATED COSTS  
73 PROGRAM CAPITAL-RELATED COSTS  
74 INPATIENT ROUTINE SERVICE COST  
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS  
76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION  
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION  
78 INPATIENT ROUTINE SERVICE COST LIMITATION  
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS  
80 PROGRAM INPATIENT ANCILLARY SERVICES  
81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION  
82 TOTAL PROGRAM INPATIENT OPERATING COSTS

## PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS  
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM  
85 OBSERVATION BED COST

## COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART I
I	14-4034	I		I	

TITLE XIX - I/P

HOSPITAL

TEFRA

## PART I - ALL PROVIDER COMPONENTS

1

## INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	37,888
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	37,888
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	37,888
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	29,481
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

## SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	15,242,051
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	15,242,051

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	34,702,872
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	34,702,872
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.439216
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	915.93
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	15,242,051

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART II
I	14-4034	I		I	

TITLE XIX - I/P

HOSPITAL

TEFRA

## PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	402.29
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	11,859,911
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	11,859,911

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT				
	HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
					1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				1,261,028
49	TOTAL PROGRAM INPATIENT COSTS				13,120,939

## PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	770,044
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	28,193
52	TOTAL PROGRAM EXCLUDABLE COST	798,237
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	12,322,702

## TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES	1,597
55	TARGET AMOUNT PER DISCHARGE	7,716.16
56	TARGET AMOUNT	12,322,708
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	6
58	BONUS PAYMENT	1
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	13,120,940
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	

## PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2008	I	PART III
I	14-4034	I		I	

TITLE XIX - I/P

HOSPITAL

TEFRA

## PART III - SKILLED NURSING FACILITY, NURSING FACILITY &amp; ICF/MR ONLY

1

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE  
SERVICE COST  
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM  
68 PROGRAM ROUTINE SERVICE COST  
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM  
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS  
71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS  
72 PER DIEM CAPITAL-RELATED COSTS  
73 PROGRAM CAPITAL-RELATED COSTS  
74 INPATIENT ROUTINE SERVICE COST  
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS  
76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION  
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION  
78 INPATIENT ROUTINE SERVICE COST LIMITATION  
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS  
80 PROGRAM INPATIENT ANCILLARY SERVICES  
81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION  
82 TOTAL PROGRAM INPATIENT OPERATING COSTS

## PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	402.29
85	OBSERVATION BED COST	

## COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		15,242,051			
87 NEW CAPITAL-RELATED COST	989,685	15,242,051	.064931		
88 NON PHYSICIAN ANESTHETIST		15,242,051			
89 MEDICAL EDUCATION		15,242,051			
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

## INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET D-4
I	COMPONENT NO:	I	TO 6/30/2008	I	
I	14-4034	I		I	

TITLE XIX

HOSPITAL

TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
26	ADULTS & PEDIATRICS		31,796,003	
27	INTENSIVE CARE UNIT			
28	CORONARY CARE UNIT			
29	BURN INTENSIVE CARE UNIT			
31	SURGICAL INTENSIVE CARE UNIT			
	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY	.480611	158,766	76,305
53	ELECTROCARDIOLOGY	.750904	392,490	294,722
56	DRUGS CHARGED TO PATIENTS	.763354	1,165,908	890,001
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.585346		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		1,717,164	1,261,028
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		1,717,164	



## CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2008	I	PART I
I	14-4034	I		I	

## PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS HOSPITAL

- 1 INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)
- 1.01 HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)
- 1.02 ENTER FROM THE PS&R, THE IRF PPS PAYMENT
- 1.03 MEDICAID SSI RATIO (IRF PPS ONLY) (SEE INSTR.)
- 1.04 INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)
- 1.05 OUTLIER PAYMENTS
- 1.06 TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)
- 1.07 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)
- INPATIENT PSYCHIATRIC FACILITY (IPF)
- 1.08 NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)
- 1.09 NET IPF PPS OUTLIER PAYMENTS
- 1.10 NET IPF PPS ECT PAYMENTS
- 1.11 UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)
- 1.12 NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)
- 1.13 CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)
- 1.14 CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)
- 1.15 INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)
- 1.16 AVERAGE DAILY CENSUS (SEE INSTRUCTIONS) 103.519126
- 1.17 MEDICAL EDUCATION ADJUSTMENT FACTOR  $\{((1 + (LINE 1.15/1.16))) \text{ RAISED TO THE POWER OF } .5150 - 1\}$ .
- 1.18 MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).
- 1.19 ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)
- 1.20 STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)
- 1.21 ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)
- 1.22 STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE 1.19 OTHERWISE ENTER -0--)
- 1.23 TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19 AND 1.22)
- INPATIENT REHABILITATION FACILITY (IRF)
- 1.35 UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)
- 1.36 NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)
- 1.37 CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)
- 1.38 CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)
- 1.39 INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)
- 1.40 AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)
- 1.41 MEDICAL EDUCATION ADJUSTMENT FACTOR  $\{((1 + (LINE 1.39/1.40))) \text{ RAISED TO THE POWER OF } .9012 - 1\}$ .
- 1.42 MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).
- 2 ORGAN ACQUISITION
- 3 COST OF TEACHING PHYSICIANS
- 4 SUBTOTAL (SEE INSTRUCTIONS)
- 5 PRIMARY PAYER PAYMENTS
- 6 SUBTOTAL
- 7 DEDUCTIBLES
- 8 SUBTOTAL
- 9 COINSURANCE
- 10 SUBTOTAL
- 11 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV'S)
- 11.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)
- 11.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
- 12 SUBTOTAL
- 13 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
- 13.01 OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)
- 14 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION
- 15 OTHER ADJUSTMENTS (SPECIFY)
- 15.99 OUTLIER RECONCILIATION ADJUSTMENT
- 16 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2008	I	PART I
I	14-4034	I		I	

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS  
HOSPITAL

RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS

17 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)

18 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)

19 INTERIM PAYMENTS

19.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)

20 BALANCE DUE PROVIDER/PROGRAM

21 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)  
IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

----- FI ONLY -----

50 ENTER THE ORIGINAL OUTLIER AMOUNT FROM E-3, I LN 1.05 (IRF)  
OR 1.09 (IPF).

51 ENTER THE OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)

52 ENTER THE INTEREST RATE USED TO CALCULATE THE TIME VALUE  
OF MONEY. (SEE INSTRUCTIONS).

53 ENTER THE TIME VALUE OF MONEY.

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2008	I	PART III
I	-	I		I	

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	TITLE XIX	HOSPITAL	TEFRA TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
1	COMPUTATION OF NET COST OF COVERED SERVICE			
2	INPATIENT HOSPITAL/SNF/NF SERVICES		13,120,940	
3	MEDICAL AND OTHER SERVICES		680,684	
4	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
5	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
6	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
7	SUBTOTAL		13,801,624	
8	INPATIENT PRIMARY PAYER PAYMENTS			
9	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL		13,801,624	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES		31,796,003	
11	ANCILLARY SERVICE CHARGES		2,955,181	
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			1
16	TOTAL REASONABLE CHARGES		34,751,185	
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
18	PAYMENT FOR SERVICES ON A CHARGE BASIS			
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT			
	BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
19	RATIO OF LINE 17 TO LINE 18			
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		34,751,185	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		20,949,561	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES		13,801,624	
	PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS			
25	OUTLIER PAYMENTS			
26	PROGRAM CAPITAL PAYMENTS			
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
30	SUBTOTAL		13,801,624	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE		13,801,624	
	XVIII ENTER AMOUNT FROM LINE 30			
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL		13,801,624	
36	COINSURANCE			
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)		13,801,624	
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
	PAYMENT FOR SERVICES ON A CHARGE BASIS			
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
	FOR PAYMENT OF PART A SERVICES			
45	RATIO OF LINE 43 TO 44			
46	TOTAL CUSTOMARY CHARGES			
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
50	OTHER ADJUSTMENTS (SPECIFY)			
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
52	SUBTOTAL		13,801,624	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		13,801,624	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS		23,001,402	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
58	BALANCE DUE PROVIDER/PROGRAM		-9,199,778	
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2008	I	PART III
I	-	I		I	

TITLE XIX

HOSPITAL

TEFRA  
TITLE V OR  
TITLE XIX  
1

TITLE XVIII  
SNF PPS  
2

IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

## BALANCE SHEET

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	
I		I	TO 6/30/2008	I	WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
1 CURRENT ASSETS				
2 CASH ON HAND AND IN BANKS	-1,831			
3 TEMPORARY INVESTMENTS				
4 NOTES RECEIVABLE				
5 ACCOUNTS RECEIVABLE	4,287,420			
6 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY				
8 PREPAID EXPENSES				
9 OTHER CURRENT ASSETS	287,024			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	4,572,613			
12 FIXED ASSETS				
12 LAND	3,865,600			
12.01				
13 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	6,210,472			
14.01 LESS ACCUMULATED DEPRECIATION				
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	1,082,570			
18.01 LESS ACCUMULATED DEPRECIATION	-966,437			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	10,192,205			
22 OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS	65,724,501			
25 OTHER ASSETS	11,853			
26 TOTAL OTHER ASSETS	65,736,354			
27 TOTAL ASSETS	80,501,172			

## BALANCE SHEET

IN LIEU OF FORM CMS-2552-96 (06/2003)

I PROVIDER NO:	I PERIOD:	I PREPARED 11/19/2008
I 14-4034	I FROM 7/ 1/2007	I
I	I TO 6/30/2008	I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	518,356			
29 SALARIES, WAGES & FEES PAYABLE	1,109,833			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	735,020			
36 TOTAL CURRENT LIABILITIES	2,363,209			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	47,944,660			
42 TOTAL LONG-TERM LIABILITIES	47,944,660			
43 TOTAL LIABILITIES	50,307,869			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	30,193,303			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	30,193,303			
52 TOTAL LIABILITIES AND FUND BALANCES	80,501,172			

## STATEMENT OF CHANGES IN FUND BALANCES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET G-1
I		I	TO 6/30/2008	I	

	GENERAL FUND	SPECIFIC PURPOSE FUND
	1	2
	3	4
1 FUND BALANCE AT BEGINNING		18,664,187
2 OF PERIOD		
3 NET INCOME (LOSS)		11,529,116
4 TOTAL		30,193,303
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 ADDITIONS (CREDIT ADJUSTM		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		30,193,303
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13 DEDUCTIONS (DEBIT ADJUSTM		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		30,193,303
PERIOD PER BALANCE SHEET		

	ENDOWMENT FUND	PLANT FUND
	5	6
	7	8
1 FUND BALANCE AT BEGINNING		
2 OF PERIOD		
3 NET INCOME (LOSS)		
4 TOTAL		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 ADDITIONS (CREDIT ADJUSTM		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13 DEDUCTIONS (DEBIT ADJUSTM		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		
PERIOD PER BALANCE SHEET		

## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET G-2
I		I	TO 6/30/2008	I	PARTS I & II

## PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	44,243,312		44,243,312
2 00 SUBPROVIDER	2,554,499		2,554,499
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
7 00 NURSING FACILITY			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	46,797,811		46,797,811
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	46,797,811		46,797,811
17 00 ANCILLARY SERVICES	2,213,084		2,213,084
18 00 OUTPATIENT SERVICES		2,463,631	2,463,631
24 00 PHYSICIAN REVENUE	529,620		529,620
25 00 TOTAL PATIENT REVENUES	49,540,515	2,463,631	52,004,146

## PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		24,165,438	
ADD (SPECIFY)			
27 00 BAD DEBT EXPENSE	4,054		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		4,054	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		24,169,492	



## STATEMENT OF REVENUES AND EXPENSES

IN LIEU OF FORM CMS-2552-96 (09/1996)

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/19/2008
I	14-4034	I	FROM 7/ 1/2007	I	WORKSHEET G-3
I		I	TO 6/30/2008	I	

## DESCRIPTION

1	TOTAL PATIENT REVENUES	52,004,146
2	LESS: ALLOWANCES AND DISCOUNTS ON	16,343,842
3	NET PATIENT REVENUES	35,660,304
4	LESS: TOTAL OPERATING EXPENSES	24,169,492
5	NET INCOME FROM SERVICE TO PATIENT	11,490,812
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	13,768
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	12,972
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	3,047
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	MISCELLANEOUS INCOME	8,517
24.01		
24.02		
25	TOTAL OTHER INCOME	38,304
26	TOTAL	11,529,116
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	11,529,116